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DEPT. OF PSYCHIATRY, SCHOOL OF MEDICINE &
MANDEL SCHOOL OF APPLIED SOCIAL SCIENCES

Center for
Evidence-Based
Practices

Ohio Substance Abuse and Mental Illness
Coordinating Center of Excellence
OHIO **SAMI** CCOE

MEDICAL PROFESSIONALS

& INTEGRATED DUAL DISORDER TREATMENT 

the evidence-based practice

**Research shows
that 1 out of 2
people with
severe mental
illness in your
practice will
experience a
problem with
alcohol, tobacco,
and other drugs
at some point in
their lives.**



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Why is this important?

PROBLEM

TWO DISORDERS

Research shows that over 50 percent of people in the United States who have been diagnosed with a severe mental illness will also have a diagnosable co-occurring substance use disorder (alcohol or other drugs) during their lifetimes.

[D. A. Regier, M. E. Farmer, D. S. Rae, B. Z. Locke, S. J. Keith, L. L. Judd, and F. K. Goodwin (1990). Comorbidity of Mental Disorders with Alcohol and other Drug Abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, v264, n19 November, p2511-2518.]

SEPARATE SERVICES

Historically, people with co-occurring disorders have been excluded from mental health treatment because of their substance use disorder. Likewise, they have been excluded from substance abuse treatment because of their severe mental health symptoms. As a result, they frequently have not gotten the help they need.

NEGATIVE LIFE OUTCOMES

Individuals with co-occurring disorders are more likely to experience the following:

- Psychiatric episodes
- Use, abuse, and relapse to alcohol and other drugs
- Hospitalization and emergency room visits
- Relationship difficulties
- Violence
- Suicide
- Arrest and incarceration
- Unemployment
- Homelessness
- Poverty
- Infectious diseases, such as HIV, hepatitis, and sexually transmitted diseases
- Complications resulting from chronic illnesses such as diabetes and cancer

SOLUTION

INTEGRATED TREATMENT

The Integrated Dual Disorder Treatment (IDDT) model combines substance abuse services with mental health services and helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. IDDT is multidisciplinary and combines pharmacological, psychological, educational, and social interventions to address the needs of consumers and their family members in a culturally sensitive manner. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. Treatment is individualized to address the unique circumstances of each person's life.

Evidence-Based Practice | EBP

Research has demonstrated that IDDT produces improved consumer outcomes, program outcomes, and service systems outcomes. Research also shows that organizations which maintain fidelity to the core components of IDDT achieve and sustain the best results (see sidebar).

A BETTER LIFE

IMPROVED OUTCOMES

IDDT Decreases

- Duration, frequency, and intensity of mental and substance use disorder symptoms
- Hospitalization
- Arrest and incarceration
- Duplication of services
- Treatment drop-out
- Utilization of high-cost services

IDDT Increases

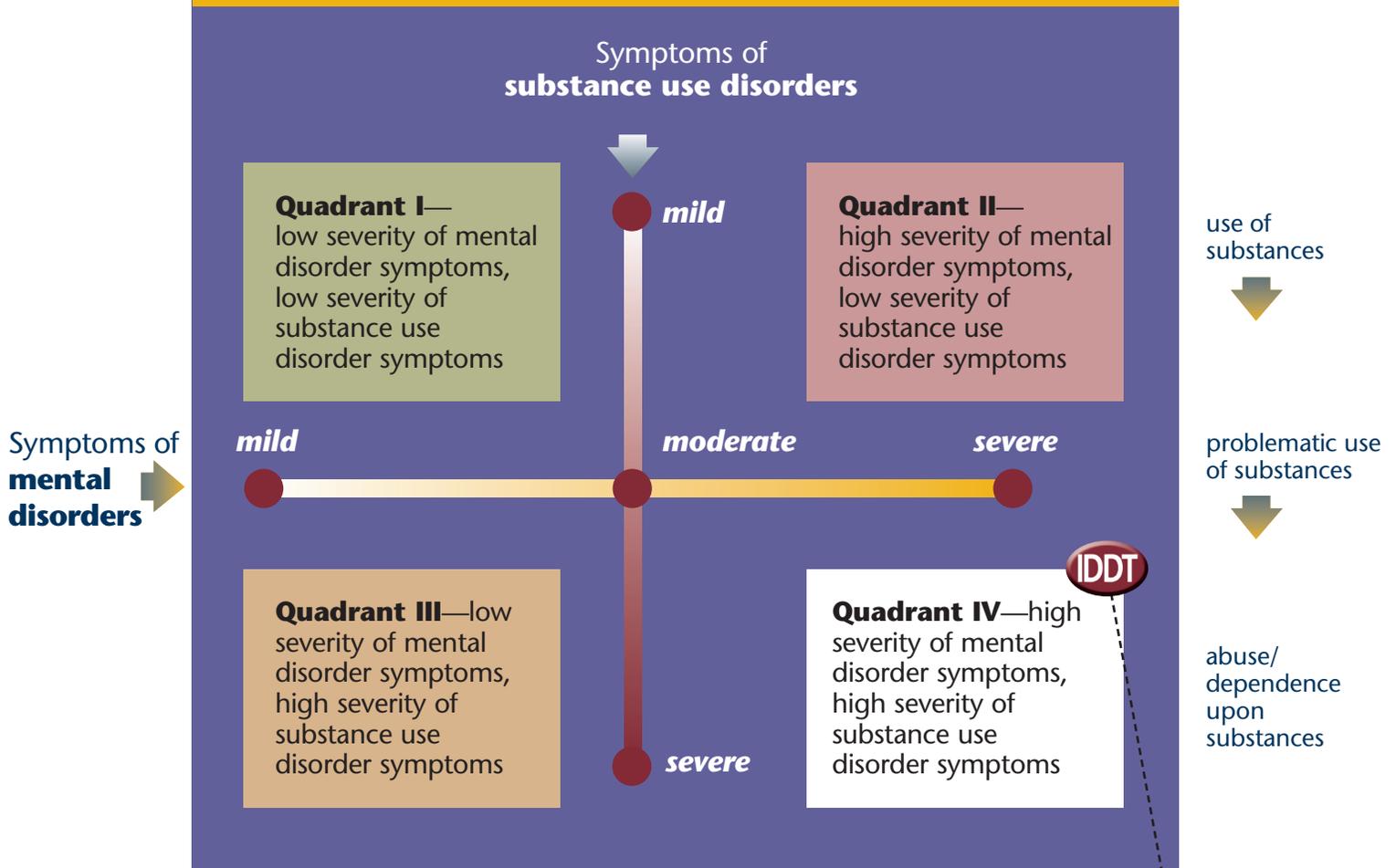
- Abstinence from use of alcohol and other drugs
- Continuity of care
- Improved relationships
- Consumer quality-of-life
- Stable housing
- Independent living



IDDT is built upon the following core treatment components:

- **Multidisciplinary Team**
- **Stage-Wise Interventions**
- **Access to Comprehensive Services (e.g., residential, employment, etc.)**
- **Time-Unlimited Services**
- **Assertive Outreach**
- **Motivational Interventions**
- **Substance Abuse Counseling**
- **Group Treatment**
- **Family Psychoeducation**
- **Participation in Alcohol & Drug Self-Help Groups**
- **Pharmacological Treatment**
- **Interventions to Promote Health**
- **Secondary Interventions for Treatment of Non-Responders**

Quadrant Framework of Symptom Severity



Adapted from the following: ❶ Mark I. Singer, PhD, Marilyn J. Kennedy, and Lenore Kola, PhD (1998). A Conceptual Model for Co-Occurring Mental and Substance-Related Disorders. *Alcoholism Treatment Quarterly*, v16, n4, p75-89. ❷ RK Ries, NS Miller (1993). *Dual diagnosis: concept, diagnosis, and treatment, in current psychiatric therapy*. Edited by DL Dunner. Philadelphia: W. B. Saunders, p131-138.

LIVING IN THE COMMUNITY

Most people with severe mental illness receive treatment in the least restrictive environment as possible—not in the hospital but in the community, where many social and economic situations and circumstances influence and affect their symptoms, health, and well-being. These situations and circumstances may include the following:

- Access to safe, affordable, and stable housing
- Access to competitive employment and stable income (from benefits, employment, etc.)
- Medical care and insurance
- Relationships with peers/friends
- Relationships with family members
- Involvement with the criminal justice system



IDDT THE
INTEGRATED
DUAL DISORDER
TREATMENT
(IDDT) MODEL
WAS DEVELOPED
FOR PEOPLE
WHOSE
SYMPTOMS ARE
MOST SEVERE.



How does my practice change?

Rx
MEDICATION IS AN IMPORTANT ALLY, ESPECIALLY WHEN COMBINED WITH PSYCHOSOCIAL TREATMENTS.

IDDT WILL ENHANCE THE OUTCOMES OF YOUR PRACTICE, BECAUSE YOU WILL . . .

- Not work alone but as a member of a multidisciplinary team
- Combine medication with psychosocial treatments, such as motivational interviewing
- Take a stage-wise approach to treatment
- Discover that *big* changes like sobriety and symptom management occur over time through *small, incremental* steps
- Discover that people can and do recover from addiction and severe mental illness

GOALS OF TREATMENT

Abstinence is a long-term goal but not the only one. Treatment goals often include the following:

- Fulfill daily-living needs/quality-of-life needs (e.g., to reconnect with family members, to find a safe and affordable place to live, to find a part-time or full-time job, etc.)
- Reduce substance use
- Stop the progression of addiction and mental illness
- Increase awareness and self-management of cravings and other symptoms of both disorders
- Reduce the negative impact of symptoms of both disorders
- Replace harmful psychological defense mechanisms with adaptive coping mechanisms
- Utilize daily living skills to increase independent living in the community

- Increase meaningful activities (e.g., school, work)
- Improve social relationships (e.g., with family members, friends, co-workers who support abstinence and recovery)
- Long-term abstinence from substance use
- Long-term psychiatric stability
- Improve overall physical health and well-being

STAGE-WISE TREATMENT

Medications are combined with different psychosocial treatments during the four stages of integrated treatment to help consumers decrease and eventually eliminate their substance use and to help consumers manage symptoms of both disorders. There are four stages of IDDT treatment:

- Engagement
- Persuasion
- Active treatment
- Relapse prevention

These stages are built upon the stages of change but are specific to the treatment of co-occurring disorders (see table below).

IDDT team members utilize the stages of treatment to stay in-step with each consumer—so you are not too far ahead (i.e., expect too much) or too far behind (i.e., expect too little) of his or her readiness, willingness, and ability to change.

MOTIVATIONAL INTERVIEWING | MI

Motivational interviewing (MI) is a therapeutic conversational technique that enables you to help consumers identify, verbalize, and own their desires and needs for a better life as well as their ambivalence to change. Their desires and needs are their goals for recovery—their intrinsic motivation for positive change. For example, a consumer may

The stages of change are adapted from the following.
 James O. Prochaska, John C. Norcross, Carlo O. DiClemente (1995). *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward*. New York: Harper Collins.

The stages of treatment are adapted from the following.
 Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guilford Publications, Inc.

FC Osher and LL Koefed (1989). Treatment of Patients with Psychiatric and Psychoactive Substance Abuse Disorders. *Hospital and Community Psychiatry*, v40, p1025-1030.

STAGE-WISE TREATMENT		
STAGES OF CHANGE	STAGES OF IDDT TREATMENT	CLINICAL FOCUS
Pre-Contemplation	Engagement	Build a relationship and working alliance with the consumer; provide practical support for daily living; assess continuously
Contemplation and Preparation	Persuasion	Help the engaged client develop the motivation to reduce substance use and to participate in other recovery-oriented interventions
Action	Active Treatment	Help the motivated client acquire skills and supports for managing symptoms of both disorders and for pursuing goals
Maintenance	Relapse Prevention	Help clients in stable remission develop and use strategies for maintaining abstinence and recovery

not want to acknowledge or talk about her addiction to cocaine or the occurrence of hallucinations. However, she might admit that she would like to find a new apartment in a safe neighborhood. Make this the primary focus of your therapeutic work. Help her notice how her drug abuse and mental illness may be preventing her from finding and keeping the apartment of her dreams.

With MI, you help identify each person's readiness, willingness and ability to change. MI intentionally avoids confrontation to minimize defensive responses from consumers and to decrease their resistance to working with you.

MEDICATION TREATMENT

Psychiatrists and other medical professionals tend to be wary of prescribing psychotropic medication to people with severe mental illness who are actively drinking and using other drugs. They are afraid the chemical mix might have negative consequences. Yet, substance abuse among people with severe mental disorders is very common, so it is important to increase your knowledge and comfort level in treating both disorders simultaneously. Research shows that medications are most effective when combined with psychosocial treatments.

PRESCRIBE MEDICATION FOR BOTH DISORDERS

In the first two stages of treatment (i.e., engagement and persuasion) consumers are not ready to stop drinking or using other drugs. Therefore, it may not be reasonable to require consumers to be abstinent prior to prescribing psychiatric medication.

Reasons to prescribe

It is likely that you are already prescribing psychiatric medication to patients who are active substance users. You may not realize it, because many consumers elect not to tell you how much they are actually using alcohol or other drugs.

Prescribing to active substance users is better than not prescribing at all. Without psychiatric medication, your patient experiences *two* untreated chronic brain diseases that have very negative consequences (see "Negative life outcomes" on page 2). Medication will likely make a positive impact upon both illnesses.

Potential risks and effective safeguards

Explain to consumers that using alcohol and other drugs while taking psychiatric medication is not recommended. The medication will be much less effective in the presence of other substances. Also, the mixture of chemical properties of medication and chemical properties of alcohol or other drugs may cause harmful physical effects. Clearly document in each consumer's medical record the following:

- That you have explained the risks
- That the consumer understands the risks
- That the consumer has given you consent for treatment

- That you are actively working with him or her and other service team members to monitor the physical and psychological effects of medication and substance use and will make adjustments to minimize negative effects

OFFER MEDICATIONS THAT DECREASE CRAVINGS OR SUBSTANCE USE

In general, patients who are in the late persuasion, active treatment, or relapse prevention stages of treatment are the most appropriate candidates for medications that reduce cravings and substance use. They have expressed an interest in and have exhibited behavior that demonstrates a desire to cut down substance use. There are currently several medications available to treat cravings and to prevent relapse.

DECREASE OR AVOID MEDICATIONS THAT HAVE ADDICTIVE POTENTIAL

Medications for psychiatric symptoms and general health concerns that have addictive potential should be used sparingly and with extreme caution in patients with a history of substance abuse and dependence. These often include the following:

- Benzodiazepines
- Stimulants
- Controlled sleep aids

Know your patient

There are certain situations in which you may consider prescribing benzodiazepines or stimulants to consumers with a history of substance use disorders. In these cases, it is most helpful to know your patient for an extended period of time. This will give you a chance to observe how he or she reacts to medications and other forms of treatment.

Precautions

If you choose to prescribe a potentially addictive medication, here are some helpful tips for managing treatment:

- Document the clinical rationale for the medication.
- Document that you have explained the danger to the consumer and that he or she understands the addictive potential of the medication and the risks involved in taking it.
- Prescribe small amounts with no refills.
- Insist on "one prescriber, one pharmacy" for all controlled substances.
- Utilize treatment team members to check on consumers frequently to ensure they are adherent with the regimen and to identify what other substances they may be using.
- Have a documented plan in place prior to prescribing controlled substances, in case the patient misuses the medication or relapses to use alcohol or other drugs. This plan could include the following:
 - What to do in case of withdrawal symptoms
 - What alternative treatments will be offered
 - Whether/if controlled substances will be offered again to that patient ■

Five Strategies for Medical Professionals

- 1. Be trained**
in the IDDT model
- 2. Give medication**
even if the consumer is still using alcohol or other drugs
- 3. Treat addiction**
with appropriate medications
- 4. Avoid medication**
known to increase addiction
- 5. Communicate regularly**
with members of the multidisciplinary IDDT service team



How do I fit in?

CONSUMER-CENTERED TEAM APPROACH

Many consumers and physicians are accustomed to the doctor “being the expert and being in charge.” However, with IDDT, the relationship with each consumer is one of partnership and collaboration.

Team members listen carefully to what each person wants to achieve—whether it’s reducing the amount of alcohol and other drugs he or she uses, staying out of the hospital, reconnecting with family and friends, or finding and keeping a safe and affordable place to live. For many, their goal is to find a competitive part-time or full-time job.

All treatment activities, including medication management, are intended to help consumers achieve their stated goals. Team members verbalize this to consumers, reminding them from time to time if they forget.

MULTIDISCIPLINARY TEAM

The IDDT model views all activities of life as part of the recovery process. Therefore, a variety of service providers help each consumer in all aspects of life (see sidebar).

The multidisciplinary treatment team meets regularly to discuss each consumer’s progress in all areas of his or her life and to provide insights and advice to one another. Team members also meet individually and as a group with each consumer and their caregivers (family, friends, and other supporters) to discuss the consumer’s progress and goals.

THE CLINICAL LEADER

Psychiatrists and other physicians are among the most highly credentialed members of the team and, thus, provide de facto clinical leadership. They are ultimately accountable for all medical decisions and, therefore, are responsible for any legal consequences related to treatment.

Physicians have authority for the following:

- Writing prescriptions
- Hospital admissions, both voluntary and involuntary
- Recommending payee relationships (money management)
- Recommending legal guardianship

Physicians are also in the position to encourage, influence, and help consumers access services that will support their efforts. For example:

- Housing
- Employment
- Medical care (e.g., for diabetes, hypertension)

CLINICAL SUPERVISION AND CONSULTATION

The IDDT team leader provides clinical supervision to IDDT service team members. The physician usually provides direct clinical

supervision to medical residents and fellows, nurses, advanced practice nurses, physician assistants, and other medical professionals. He or she also provides indirect clinical supervision to other team members in the form of clinical oversight: this informal supervision typically occurs as consultation. Psychiatrists might also collaborate with physicians who work outside of the community mental health center (e.g., primary care and emergency room physicians and obstetricians/gynecologists).

POSITIVE PERSONAL ATTRIBUTES

There are personal attributes which create an interpersonal environment that validates each consumer’s goals for recovery and encourages their efforts:

Patience and persistence

Maintain a long-term view of the recovery process. Consumer reluctance about treatment and relapse are a part of the recovery process.

Realistic optimism

It is important to convey hope with constant encouragement and by pointing out small steps toward success. Take a proactive stance to avert crises by treating symptoms. It is especially important not to judge or punish consumers for displaying symptoms of their illnesses.

Approachability

Have an open-door policy to increase your availability to all team members. An egalitarian and diplomatic style conveys respect and the importance of everyone’s contribution to the continuity of care for consumers.

Learning & Teaching

The processes of learning and teaching involve humility and openness to new ideas and strategies. A good teacher knows her audience, gives timely and relevant information, and provides ongoing feedback.

Networking

You are not in this alone. The team approach helps increase efficiency in and decrease frustration with treatment. Remember that the team reduces risk by becoming an extension of your practice.

Coordinating

Prevent consumers from “falling through the cracks” that exist between service systems by having a working knowledge of other systems of care in your local community, for example:

- Local emergency room
- Psychiatric hospital
- Criminal justice system
- Housing services
- Vocational services
- Child and family welfare/services ■

THE TEAM

Service providers from multiple disciplines and systems of care help consumers access and utilize resources.

The team consists of the following:

- Team leader
- Case manager(s)
- Nurse
- Psychiatrist
- Mental health professional
- Substance abuse professional
- Criminal justice specialist/liaison
- Supported Employment specialist
- Housing specialist
- Family specialist

How do I advocate for change?

Many people in service systems, organizations, and local communities value the clinical opinions of psychiatrists and other medical professionals because they are among the most highly credentialed providers of healthcare and behavioral healthcare. As a result, medical professionals have the opportunity to provide a strong voice of advocacy for evidence-based practices such as IDDT. It is important for administrators, program managers, service team leaders, and medical professionals to work collaboratively for a unified voice of advocacy.

THE MOTIVATION FOR CHANGE

It is helpful to utilize stages-of-treatment and motivational approaches in your advocacy, especially with people who are unfamiliar with or doubtful about the positive outcomes produced by integrated treatment. Adjust your approach and response to each person accordingly.

To raise awareness, help everyone involved with service delivery (e.g., policy makers, administrators, direct-service providers, family members and other advocates) evaluate the fit between the mission of the service system or organization and current practices. Here are a few basic questions with which to start:

Mission

- What is the purpose of our service system and/or organization?

Service needs

- What assumptions do we make about people with co-occurring disorders in our community?
- Have we considered how many residents of our community may have co-occurring disorders?
- Are there standardized screening and assessment instruments available, and are they being used regularly?
- Are people with co-occurring disorders currently receiving treatment for both disorders at the same time and place?
- Do we know their unmet daily-living needs and treatment needs?

ORGANIZATIONAL CHANGE

There are advantages to the long-term clinical perspective of IDDT. Organizations will see improvement over time. Therefore, some outcomes may come early in the treatment process, while others may take longer.

Attend IDDT team meetings

Psychiatrists and other medical professionals should advocate for their own attendance at IDDT team meetings. If physicians do not attend, their knowledge of consumer needs may suffer. Organizations that do make attendance a priority send a powerful message to everyone in the organization and the community about the importance of integrated treatment. To advocate for IDDT, you might also consider participating in the following:

- Agency-based steering committees
- IDDT fidelity reviews
- Creating fidelity action plans
- Attending and conducting training sessions

SYSTEMS CHANGE

Medical professionals may advocate for consumers who find themselves in non-integrated systems of care. Some strategies are briefly described below.

Pilot projects

You may be able to influence the mental health and/or substance abuse services authority to create a pilot project that uses the IDDT model and supports technical assistance for implementing the model.

Other initiatives

- Participate in planning meetings of the mental health and/or substance abuse authority.
- Participate in grant-funded demonstration projects and research projects that aim to promote the IDDT model.
- Speak to the media or to other community stakeholders about the benefits of IDDT.
- Participate in regional IDDT steering committees, which often include representatives from all systems that provide services to or interact with consumers who have co-occurring disorders (e.g., hospitals and emergency rooms, criminal justice, child welfare, education, and vocational rehabilitation). These committees are designed to integrate and streamline services. ■



Big changes occur in small, incremental steps over time.

Begin advocating today for evidence-based practices to treat individuals with co-occurring disorders.

OHIO SAMI CCOE

IDDT

ABOUT US

The Ohio SAMI CCOE is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people with mental and substance use disorders. The SAMI CCOE helps service systems, organizations, and providers implement and sustain the Integrated Dual Disorder Treatment (IDDT) model, maintain fidelity to the model, and develop collaborations within local communities that enhance the quality of life for consumers and their families. The SAMI CCOE provides these services:

- Service systems consultation
- Program consultation
- Clinical consultation
- Training
- Evaluation (fidelity and outcomes)
- Research



This booklet is part of an evolving training and consultation process from the Ohio SAMI CCOE. It is written for medical professionals and other direct-service providers who want to implement and sustain the IDDT model. It is also written for administrators, policy makers, and advocates.

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**Consultations and training events are available
for medical professionals.**

www.centerforebp.case.edu/events

**For more information about the clinical components of
IDDT, consult these resources:**



*Integrated Dual Disorder
Treatment (IDDT)
Overview (2003).*
Cleveland: Center for
Evidence-Based Practices,
Case Western Reserve
University. A 6-page at-a-
glance look at the clinical
components of IDDT.

[http://www.ohiosamiccoe.
case.edu/library/resource.
cfm?resourceid=87](http://www.ohiosamiccoe.case.edu/library/resource.cfm?resourceid=87)



*Clinical Guide to Integrated
Dual Disorder Treatment
(IDDT).* Cleveland: Center
for Evidence-based
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Reserve University. A more
in-depth exploration
of the clinical components
of IDDT.

[http://www.ohiosamiccoe.
case.edu/library/resource.
cfm?resourceid=152](http://www.ohiosamiccoe.case.edu/library/resource.cfm?resourceid=152)



Resources

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ADDICTION PSYCHIATRY FELLOWSHIP

One-year post-residency fellowships are
available in addiction psychiatry and
community psychiatry at the Dept. of
Psychiatry, Case School of Medicine.

[www.ohiosamiccoe.case.edu/library/
media/addictionpsychiatryfellowship.pdf](http://www.ohiosamiccoe.case.edu/library/media/addictionpsychiatryfellowship.pdf)

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Build trust
Improve outcomes
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